How Psychiatrists Continue To Learn: Operations and Practices of Continuous Professional Development Peer Groups

Itoro Udo[1], Adetokunbo Shangobiyi[2], Uchenna Njoku[3], Tuoyo Awani[4], Tamunoemi Eleye-Datubo[5]

Abstract

Aims: To investigate whether the operations of Continuous Professional Development (CPD) peer groups, within a mental health service in North East England, were compliant with guidelines and recommended standards for continuous professional development. Tees, Esk, Wear Valleys NHS Foundation Trust is one of the largest mental health providers in the United Kingdom. It had 33 identified CPD peer groups at the time.

Methods: Standards were derived from the Continuing Professional Development Guideline of the Royal College of Psychiatrists, UK. An audit proforma was generated based on the standards and questionnaires were created to identify compliance with standards. This was an audit conducted as an electronic questionnaire survey, as reported by co-ordinators of identified peer groups. This was conducted in November 2013.

Results: Thirty (30) peer group co-ordinators responded (response rate of 90%). Twenty-Seven (27) groups (90%) had all members enrolled in an approved CPD programme. Twenty-Three (23) groups (76%) met the recommended size of membership. A co-ordinator was clearly identifiable in 27 groups (90%). All groups do undertake review and identification of learning objectives. Twenty-Five (25) groups (83%) do approve CPD activities and award credits. Twenty-Nine, 29 (96%) document meetings. Twenty-Eight, 28 (93.3%) do provide advice, remedies and support. Twenty-Eight, 28 (93.3%) do sign off CPD portfolios. Areas needing improvement were the provision of evidence of attendance to learning activities and evidence of reflection (80%); and invitation of external observers to observe peer group meetings (43.3%).

Conclusion: These results give confidence that continuous professional development is occurring to envisaged standards. To improve practice, groups should consider incorporating the approval of CPD activities and credits into
meetings; setting aside time for reflection and invite external observers to comment on functioning of groups. Some groups were too large and few needed a clearly identified co-ordinator and regular meeting times.

**Keywords:** Continuous Professional Development; Peer Groups; Psychiatry; Psychiatrists; Doctors; Continuous Medical Education

**Introduction**

The primary purpose of Continuous Professional Development (CPD) peer groups is to foster the delivery of high quality clinical care amongst healthcare professionals by supporting them to systematically refresh and update their knowledge and skills. Continuous professional development has been defined as "a process of self-assessment, self-directed, lifelong learning that complements formal undergraduate and postgraduate education and training" (Royal College of Psychiatrists, 2015). Continuous professional development enables psychiatrists to acquire new knowledge and skills as well as to maintain and improve standards of care across areas of practice. In the UK, the organisation and running of CPD Peer groups is a tool for quality assurance in postgraduate medical education and conversely, clinical governance. Hence its activities contribute to increased assurance in yearly appraisals and revalidation (General Medical Council, 2012).

In order to maintain one's practicing licence in the UK, non-training doctors (consultants, associate specialists and specialty doctors) are expected to belong to a peer group and use its operations to plan, monitor, improve and support their professional development (General Medical Council, 2012). Hence, significant oversight for postgraduate professional development have been devolved to peer groups. CPD peer grouping was given noteworthy mention in the Francis Report into poor care in Staffordshire NHS Foundation Trust, UK, in 2013, which observed that

"Peer review is an invaluable means of spreading and maintaining a positive common culture in which good practice is encouraged to flourish and bad practice can be identified and remedied. It should be an intrinsic part of the practice" (The Mid Staffordshire NHS Foundation Trust Public Enquiry, 2013).

It is therefore in the interests of regulatory authorities, the medical profession and patient care that these groups are supported to carry out their expected functions. However, there appears to be limited information on how these groups, where existent, operate or the quality of its activities.

The Royal College of Psychiatrists, UK (RCPsych) does support continuous professional development among its members, fellows and affiliates. This is through two major means: the provision of an official, online CPD submissions programme and a CPD online learning portal. The RCPsych CPD submissions programme enables those registered to record their CPD activities electronically and are granted a certificate of good standing yearly for the purposes of appraisal and revalidation. Part of the requirements for this annual certification is the authentication of learning activities and credits by one's CPD peer group (Royal College of Psychiatrists, 2013). While the RCPsych CPD online learning portal hosts educational modules and podcasts which registered members may study and generate certificates on completion which may be used as evidence of learning and may be posited in its CPD Submissions programme. Up to 25 CPD hours may be demonstrated using this Royal College of Psychiatrists CPD Online portal (Royal College of Psychiatrists, 2013).

According to RCPsych guideline, peer groups are expected to meet at least once every quarter of the year. In these meetings, members are expected to discuss and agree on their learning plans for each CPD yearly cycle. They would agree on educational activities that would meet each learning plan. Meetings are meant to be documented including progress made by members in realising their plans. They would also be expected to agree on the appropriate credits to be claimed for each learning activity as well as agree on the number of credits obtained by each member at the
end of their yearly cycle. Support and advice are expected to be offered to those experiencing difficulties of various degree and complexity, such as accessing appropriate educational activity to meet a particular plan. Members are expected to retain documentation of their participation in meetings in their portfolios. These groups may choose to discuss research, evidences or clinical cases and offer advice. These are referred to as "higher order" activities. They are also advised to engage in reflective exercises. Members are allowed to claim credits for studies or academic activities carried out privately such as reading books, subject to the production of evidence of having learned in the processes (Royal College of Psychiatrists, 2015).

This study was conducted in Tees, Esk and Wear Valleys NHS Foundation Trust. This is a large healthcare provider, delivering mental health services to people living across a wide geographic area in parts of North East England (County Durham and Teesside), North Yorkshire (Scarborough, Whitby, Ryedale, Harrogate, Hambleton and Richmondshire) and the Vale of York. Tees, Esk, Wear Valleys NHS Foundation Trust covers an area of up to 3,600 square miles (Tees, Esk, Wear Valleys NHS Foundation Trust, 2019). Doctors working in the Trust are mainly from all subspecialties of psychiatry but includes some doctors in general practice. A hospital trust, in the UK is a healthcare organisation that delivers generic or specialised services to a defined geographical area.

We sought to investigate whether existing CPD groups within the named Mental Health Trust were operating in line with local trust standards (Tees, Esk, Wear Valleys NHS Foundation Trust, 2013) which were derived from the Royal College of Psychiatrists’ guidelines (Royal College of Psychiatrists, 2010). These standards describe the structuring, purpose and running of CPD peer groups. These standards are those from which the criteria on Table 1 were derived.

**Methods**

Existing CPD peer groups were identified through Deputy Medical Directors’ and Clinical Directors’ Offices and the Medical Development Department. A questionnaire was created to capture information about the operations of CPD groups. The types of information requested were derived from Trust standards. CPD group co-ordinators were contacted via hospital email with a request to fill in the questionnaire. They emailed or posted the questionnaire back to the study group who collated and analysed the results. The study was conducted in November 2013 over a 3 week period. It was approved as an audit by the hospital audit department. The questions allowed for responses of "yes" or "no" and a column for comments. The latter was used by the study group to assign responses where these were ambiguous. For example, a response of "partly" inserted in the comments column was discussed and a position of strict compliance to the standards was adopted by assigning such responses to the negative.

**Results**

Thirty Three (33) CPD peer Groups were identified. Thirty (30) group leaders responded to the questionnaire (Response rate of 90.9%). Information returned are presented in Table 1, with statistical level of precision expressed as 95% Confidence Interval (CI) and statistical significance of results expressed as P values. Statistical analyses were carried out using StatsDirect statistical software.
Table 1: Results of the Study

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Response; (95% Confidence Interval)</th>
<th>Statistical Significance, P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Members Enrolled in RCPsych CPD Programme</td>
<td>Yes: 27 (90%); 95% CI: 74-97%</td>
<td>P &lt; 0.0001</td>
</tr>
<tr>
<td>Groups of 3-6 Members</td>
<td>Yes: 23 (76.7%); 95% CI: 59-88%</td>
<td>P = 0.0052</td>
</tr>
<tr>
<td>Peer Group Co-ordinator Identified</td>
<td>Yes: 27 (90%); 95% CI: 74-97%</td>
<td>P &lt; 0.0001</td>
</tr>
<tr>
<td>Review &amp; Identify Learning Objectives</td>
<td>Yes: 30 (100%); 95% CI: 89-100%</td>
<td>P &lt; 0.0001</td>
</tr>
<tr>
<td>Approve CPD Activities &amp; Credits</td>
<td>Yes: 25 (83.3%); 95% CI: 66-92%</td>
<td>P = 0.003</td>
</tr>
<tr>
<td>Document Meetings &amp; Progress</td>
<td>Yes: 29 (96.7%); 95% CI: 66-99%</td>
<td>P &lt; 0.0001</td>
</tr>
<tr>
<td>Provision of Advice, Remedies &amp; Support</td>
<td>Yes: 28 (93.3%); 95% CI: 78-98%</td>
<td>P &lt; 0.001</td>
</tr>
<tr>
<td>Sign off CPD Portfolios</td>
<td>Yes: 28 (93.3%); 95% CI: 78-98%</td>
<td>P &lt; 0.0001</td>
</tr>
<tr>
<td>Minutes of Meetings in Portfolios</td>
<td>Yes: 27 (90%); 95% CI: 74-97%</td>
<td>P &lt; 0.0001</td>
</tr>
<tr>
<td>Invitation of External Observer</td>
<td>Yes: 13 (43.3%); 95% CI: 27-61%</td>
<td>P = 0.59</td>
</tr>
<tr>
<td>Evidence of Attendance &amp; Reflection</td>
<td>Yes: 24 (80%); 95% CI: 63-90%</td>
<td>P = 0.0014</td>
</tr>
<tr>
<td>Higher Level Activity Considered</td>
<td>Yes: 23 (76.7%); 95% CI: 59-88%</td>
<td>P = 0.0052</td>
</tr>
<tr>
<td>Identify Educational Needs, Progress, Agree Objectives &amp; Credits</td>
<td>Yes: 29 (96.7%); 95% CI: 83-99%</td>
<td>P &lt; 0.0001</td>
</tr>
<tr>
<td>Evidence for Self Accreditation</td>
<td>Yes: 22 (73.3%); 95% CI: 56-86%</td>
<td>P = 0.016</td>
</tr>
<tr>
<td>Group Approval of CPD Hours</td>
<td>Yes: 27 (90%); 95% CI: 74-97%</td>
<td>P &lt; 0.0001</td>
</tr>
</tbody>
</table>
Discussion

In the UK, the General Medical Council (GMC) expects that each doctor maintains and improves their practice through CPD. It further advises that employers and those that contract the services of doctors have a responsibility to make sure their workforce is competent, up to date and able to meet the needs of the service (General Medical Council, 2012). CPD peer groups are the main organisational configuration which ensures that CPD is taking place as required. Participation in peer groups is mandatory but individual doctors can choose the particular group they belong to. Membership of groups is also open to doctors working outside the hospital trust, for example, in private or independent practice. There was no specific requirement at the time of study that groups must be registered with the Trust hence there is a possibility that few groups may have been missed though we think this is unlikely as efforts were made to enquire from different department leads about their knowledge of existing peer groups.

This study shows that there are many areas in which good practice was taking place. There appeared to be a high level (90%) of participation by eligible doctors, represented by groups, in formal continuous professional development through enrolment with the Royal College of Psychiatrists’ continuous professional development programme. This finding is similar to a previous study conducted amongst UK Psychiatrists (Bamrah et al., 2011). The Royal College of Psychiatrists, at the time of this study, expected that groups should consist of 3 to 6 members. Seven, 7 groups (23.3%) had higher than expected numbers of members. Most of these groups did not seem to be aware that they were over the required limits and 1 of them planned to divide into 2. Some groups were clearly too large and needed to be split to maximise effectiveness. During the study, we were informed of a group that had fourteen members and had only recently split into two groups. In practice, the size of groups is important because the larger the size, the more the time needed to go through learning plans and review members’ activities.

Most groups (27, 90%) had an identified group co-ordinator. In those that did not, they seemed to use collective shared leadership. The policy of the Royal College of Psychiatrists did not make provisions for collective leadership. It also does not comment on whether leadership may be rotated. These are issues that need to be addressed in future revisions of the policy. As may be surmised from the above, the smooth running of peer groups require administrative resources and academic rigour. It is not known whether these responsibilities are factored into the job plans of the peer group co-ordinators. From our experience, this is unlikely to be the case. This may explain why some groups had adopted their chosen leadership style.

In terms of how groups operate, all groups do take time to review and identify members’ learning objectives. Five, 5 groups (16.7%) were not approving CPD activities and credits. Twenty nine, 29 (96.7%) groups were documenting their meetings and proceedings. Twenty eight, 28 (93.3%) groups confirmed that they do provide advice, remedies and provide support to members. They also sign off continuous professional development portfolios (29 groups, 96.7%) and keep minutes of meetings in their portfolios (27 groups, 90%). It was heartening to note that these core functions of peer groups were being carried out by a large majority of groups. For groups that were not approving CPD activities and credits, it was thought that this may have been related to the size of these groups and attendant burden of carrying out recommended activities within meeting times as well as the frequency of CPD peer group meetings. In that groups that meet less frequently were less likely to meet all the standards.

A major area that needed improvement is invitation of external observers to observe the proceedings of individual groups. The function of these observers is to authenticate the workings of groups and keep groups from becoming "too informal and too cosy" such stagnation is especially true of groups that have remained together for too long without any changes (Royal College of Psychiatrists, 2010). In our study, only 13 groups (43.3%, 95% CI: 27-61%) had done this. We reason that most group co-ordinators were probably not aware of this criteria and hence had not taken steps to fulfil this. Some of them commented that this would then be done.

Also, only 22 (73.3%) groups checked for evidence of self-accreditation of learning among their members. The
Royal College of Psychiatrists standard is that self-accreditation of relevant activities and documented reflective learning should be allowed and encouraged but it should be evidenced for possible audit (Royal College of Psychiatrists, 2015). Acceptable evidences may include certificates of attendance, attendance lists, and conference or course notes. A reflective note is an acceptable evidence of participation in learning. It was our thinking that because accreditation of learning was already taking place in groups, there was a reduced need for it to be done by individual learners.

Twenty three, 23 groups (76.7%) have considered or participated in what is described as higher level activities. These are activities such as sharing or discussing new evidence from medical literature or good practice, reviewing clinical management of new or rare cases. The frequency of this activity was higher than we had expected. We had reasoned that bigger groups, discussing recent education activities would have less time and opportunities for higher level activities. This result would suggest that psychiatrists are taking advantage of peer support to discuss clinical cases or activities.

Apart from the above, other issues were identified which include the fact that groups could benefit from having regular meeting times and minutes of meetings should be published among group members. The reasons why this was not routine may be linked to the administrative burden involved in co-ordinating these groups.

A review of RCPsych guidelines for peer groups was needed as some criteria appeared repetitive such as need to "review and identify learning objectives" when contrasted with need to "identify educational needs, progress, agree objectives and credits" (Royal College of Psychiatrists, 2015). This was commented on by participants in the audit. We think that current standards may be improved upon. College standards to be circulated to all members of a group, and they should acquaint themselves of content so that they act as support and checks that the coordinator is keeping to key standards. The choice of external observer should be limited to a group coordinator in order to avail of the value and experience that a coordinator will bring to observing function.

The main hindrances to complete compliance with recommended standards by groups appeared to be lack of awareness of some of these standards. For example, a peer group co-ordinator commented that "we have not been checking evidence of attendance at courses or other evidence for self-certified courses at the peer group. I presumed this was done via the College CPD programme auditing a certain percentage". A need to train peer group co-ordinators in standards expected of these groups was identified.

There was a perceived need for professional autonomy within few groups. Some groups felt they ought to be left to run themselves and self-regulate as means of promoting self-directed learning; "We operate a closed group to allow for confidential and safe peer support, to ask an observer to attend would compromise this function – we could do it but it would probably not be a typical session and observation could therefore be seen as a tick box exercise?" It may be that these groups also serve the purpose of emotional or remedial support for members who have varied work experiences and may have felt threatened by external scrutiny. There was no reason to think that the core functions of these groups had been supplanted.

There was also a potential problem of best use of time during meetings; as ability to carry out all the requirements of the college may indeed be time consuming depending on the number of peer group members and frequency of group meetings: "we have not been routinely checking everything everyone in the peer group has done prior to submitting a Form E to the college. This would be time consuming", "time constraints do not allow"; these comments were made especially in respect to carrying out higher level activities within groups. Bamrah et al, 2011 had also identified time constraints as a major constraint in the satisfactory engagement in CPD by doctors at consultant level. In their study, up to 50% of the participants were thought to have difficulties in this area, due majorly to clinical duties. This appears to remain the case.

Since this study was conducted, realising the importance of this subject, the Royal College of Psychiatrists has
updated its standards (Royal College of Psychiatrists, 2015). The new document emphasizes the place of reflection as an important tool to improve self-awareness and practice. It also emphasizes the devolved role to peer groups to assure the College of the quality of members’ CPD. It makes new recommendation that group should be composed of between 4 and 8 members. It also clarifies that psychiatrists involved in any form of clinical practice, such as part time work, would now be required to evidence requirements similar to those expected full time psychiatrists, for example at least 30 hours of “Clinical” activities. It removes previous requirement to carry out specific amounts of “internal” and “external” activities but advises learning to be accessed in the “most effective way” (Royal College of Psychiatrists, 2015) meaning that groups have a responsibility to judge whether planned activities are effective or not. It clarifies guidance for special circumstances such as periods of extended leave or absences from work and now allows private reading, if supplemented with evidence of reflection, to be accepted for up to 5 of the maximum 25 credits obtainable through e-learning.

There was no justification or evidence given for the change in numbers of peer group members. It is thought that the previous allowance of a minimum of 3 members, would have been more achievable for psychiatrists practicing in rural or isolated settings. Even though the latest guidance recognises online meetings. Some psychiatrists may be uncomfortable with discussing clinical case studies and carrying other higher level activities via commercial, non-secured electronic means.

It is observed that this updated guidance as well as the preceding one do not guarantee the quality of reflections or educational activities occurring in peer groups. This is up to CPD group co-ordinators. Perhaps this is a determination which may be made by an external observer, but then this assumes that the observer is trained and qualified to comment on the quality of such activities, as it relates to expectations from the standards.

There is a need for further, wider study of individual peer group members to highlight areas of the standards, guidelines and current practises if any that may be counterproductive and hindering the ability to achieve learning objectives, or not conducive to various learning styles/needs. The Royal colleges and individual trusts should consider facilitating platforms for dissemination of helpful resources and good practise to improve the functioning of peer groups. This could be through public/social media channels, or more localised intranet bulletins or printed newsletters.

**Limitations of the study**

It was assumed that group co-ordinators were aware of the existence of standards for CPD peer groups and any updates or changes thereof. It is possible that this may not have been the case prior to the study. There had been no co-ordinated effort, to the best of our knowledge to bring these standards to the attention of peer group co-ordinators, before our study. Our study may have been enhanced by determining the frequency of meetings of these CPD groups. Knowledge of the duration of meetings and whether these hold within or outside work hours would have been useful. These may have been parts of the reasons why some educational activities were not taking place. We did not also seek to determine whether group co-ordinators had received any training or support in the running of peer groups. This is unlikely to have occurred as there is no such course or training being offered by the said Trust at the time of the study. But this does not preclude a possibility that they could have acquired such knowledge independently. The study may have sought to determine whether there were any doctors in the Trust who were not in a peer group but this was considered as being outside the scope of the study as the Royal College of Psychiatrists expectation is that all belong to one.

**Conclusion**

There was a high level of compliance of CPD peer groups with Trust’s and conversely, Royal College of Psychiatrists’ standards for the organisation and operations of CPD peer groups within the Trust studied. The areas
in clear need of improvement were the need to invite external observers to observe and comment on the operation of peer groups; the need to check for evidence of self-accreditation of CPD credits and the need for groups to consider the regular inclusion of higher level activities in their activities. This audit has exposed the considerable administrative burden in co-ordinating peer groups.

**Take Home Messages**

- In the UK, quality assurance of continuous professional development has been devolved to doctors, self-organising as peer groups where learning activities are planned, approved and credited.
- Peer group leadership (CPD Co-ordinators) needs recognition as a medical managerial responsibility and should be discussed at job planning and annual appraisals.
- CPD coordinators should be given appropriate training and assigned administrative support.
- Trained CPD coordinators may then act as external observers to groups, ultimately raising the standards of continuous professional development.
- Formal identification of existing groups, their membership and location would make it easier for intending doctors to identify suitable groups.

**Notes On Contributors**

Dr. Itoro Udo MBBS, MSc, MRCPsych is Assistant Professor, Western University, London, Ontario & Consultant Psychiatrist, St. Joseph’s Healthcare, London, Ontario.

Dr. Adetokunbo Shangobiyi MBBS, PGDip. is Acting Consultant Psychiatrist, Mental Health Services for Older Person (MHSOP), Tees, Esk, Wear Valleys NHS Foundation Trust. UK.

Dr. Uchenna Njoku MBBS, MSc, PGCert is Lead Clinician/Associate Specialist, CGL CHART Kirklees Addiction Service, 12 Station Street, Huddersfield, UK.

Dr. Tuoyo Awani, MBBS, MRCPsych is Consultant Psychiatrist, Health Service Executive, Psychiatry of Later Life, Kildare West Wicklow Mental Health Service, Naas, Co. Kildare. Ireland.

Dr Tamunoemi (Tami) Eleye-Datubo, B.Med.Sc, MBBS, DCP is Acting Consultant Psychiatrist, Hartlepool MHSOP Community Team, Sovereign House, Hartlepool, UK. This is part of Tees, Esk, Wear Valleys NHS Foundation Trust.

Authors have all worked in Tees, Esk, Wear Valleys NHS Foundation Trust at various points in their careers.

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Bibliography/References


Appendices

None.

Declarations

The author has declared that there are no conflicts of interest.

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Ethics Statement

This study was carried out as an audit, approved by the Clinical Audit Department of Tees, Esk, Wear Valleys NHS Foundation Trust, UK. An ethics reference number was not available.

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